WISCONSIN MEDICAID

COST REPORT FOR PROVIDER-BASED RURAL HEALTH CLINICS (AFFILIATED HOSPITAL HAVING 50 OR FEWER BEDS) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of cost report data will result in no settlement determination being made.

The use of this form is voluntary, but providers are required to submit the information required on the form for a settlement determination and payment to take place.

INSTRUCTIONS: Wisconsin Medicaid-certified rural health clinics (RHCs) interested in receiving a cost settlement for services rendered to Wisconsin Medicaid recipients for a given calendar/fiscal year are required to file a cost report with the Division of Health Care Financing's RHC Auditor.

Rural health clinics that are affiliated with hospitals that have 50 or fewer beds are required to file the Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses form, HCF 11023 (Rev. 02/05) and the Cost Report for Provider-Based Rural Health Clinics (Affiliated Hospital Having 50 or Fewer Beds) form, HCF 11080 (Rev. 02/05). The forms may be filed at any time within the subsequent calendar/fiscal year for prior year activity. Cost settlements are only calculated and executed 365 days after the last date of service (DOS) for a given calendar/fiscal year by Wisconsin Medicaid.

Quarterly cost reports may be filed during the current year to streamline cash flow. Quarterly payments made by Wisconsin Medicaid to RHCs are subjected to recoupment at the time of settlement calculation if the sum of payments exceeds the annual cost settlement calculation. Rural health clinics are encouraged to be conservative in their quarterly requests.

SECTION I — PROVIDER INFORMATION

This section requires the following information from the provider:

- Facility name.
- Rural health clinic provider's Medicaid provider number.
- Date span of the reporting period.

SECTION II — DETERMINATION OF RURAL HEALTH CLINIC ENCOUNTER RATE

This section determines the cost-based encounter rate for the cost settlement. All costs listed per the Rural Health Clinic Reclassification and Adjustment of Trial Balance Expenses form should be represented in the appropriate summary section line.

Non-RHC costs are proportioned to RHC costs to determine the appropriate primary care service overhead.

The direct costs and overhead associated with primary care services are then divided among the total encounter volume experienced by the RHC in the reporting time frame for all recipients.

Due to the encounter rate being based on actual costs of operations, no Health Personnel Shortage Area (HPSA) percentage will be applied for the Medicaid recipient population seen at the provider-based RHC (affiliated hospital having 50 or fewer beds).

SECTION III — COST SETTLEMENT CALCULATION — MEDICAID-ONLY ENCOUNTERS

This section determines the interim cost settlement due to the RHC based on the Medicaid covered and reimbursed RHC services. Settlement is determined by calculating the number of encounters multiplied by the encounter rate minus any fee-for-service or HMO reimbursement received for RHC services rendered during the encounter's DOS.

This is an interim value to be used in the final calculation of Section VII.

SECTION IV — COST SETTLEMENT CALCULATION — MEDICARE / MEDICAID CROSSOVER ENCOUNTERS

This section determines the interim cost settlement due to the RHC based on the Medicare/Medicaid crossover covered and reimbursed RHC services. Settlement is determined by calculating the number of encounters multiplied by the encounter rate, minus the prorated Medicare reimbursable costs (per filed Medicare Cost Report) and fee-for-service reimbursement received for RHC services rendered during the encounter's DOS.

This is an interim value to be used in the final calculation of Section VII.

SECTION V — COST SETTLEMENT CALCULATION — COMMERCIAL INSURANCE / MEDICAID ENCOUNTERS

This section determines the interim cost settlement due to the RHC based on commercial insurance and Medicaid covered and reimbursed RHC services. Settlement is determined by the lesser of the encounter rate or amount billed for the encounter, minus any fee-for-service, HMO, and commercial insurance reimbursement received for RHC services rendered during the encounter's DOS.

Commercial insurance encounters are capped at the lesser of the straight non-HPSA encounter rate (i.e., allowable cost) or amount billed. Therefore any encounters where insurance payments are in excess of the encounter rate should be discarded from the settlement data.

This is an interim value to be used in the final calculation of Section VII.

SECTION VI — COST SETTLEMENT CALCULATION — COMMERCIAL INSURANCE / MEDICARE / MEDICAID ENCOUNTERS

This section determines the interim cost settlement due to the RHC based on the commercial insurance/Medicare/Medicaid crossover covered and reimbursed RHC services. Settlement is determined by the lesser of the encounter rate or amount billed for the encounter, minus the averaged Medicare reimbursable costs and fee-for-service reimbursement received for RHC services rendered during the encounter's DOS.

Commercial insurance encounters are capped at the lesser of the straight non-HPSA encounter rate (i.e., allowable cost) or amount billed. Therefore any encounters where insurance payments are in excess of the encounter rate should be discarded from the settlement data.

This is an interim value to be used in the final calculation of Section VII.

SECTION VII — COST SETTLEMENT DETERMINATION FOR RURAL HEALTH CLINIC

This section calculates the actual cost settlement due to the RHC. The interim calculated settlement amounts for each section are listed minus the relevant copays that could have been collected and the quarterly interim payments made by Wisconsin Medicaid to the RHC.

The balance due is then tendered via a Remittance and Status Report statement to the RHC.